UNIVERSITY OF GONDAR, COLLEGE OF MEDICINE AND HEALTH SCIENCES

INSTITUTE OF PUBLIC HEALTH

ASSESSMENT OF PARENT-ADOLESCENTS COMMUNICATION ON SEXUAL AND REPRODUCTIVE HEALTH MATTERS AND ASSOCIATED FACTORS AMONG SECONDARY AND PREPARATORY SCHOOLS STUDENTS IN AMBO TOWN, OROMIYA REGION, ETHIOPIA

BY: DEMISEW BEYENE

ADVISORS:

1. MR. RESOM BERHE
2. MR. ENDALEW GEMECHU

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BY: DEMISEW BEYENE

demise_2007@yahoo.com

Approved by the Examining Board

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Head, School of public Health

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Advisors

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Examiner

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List of acronyms

AIDS…….…. Acquired immune deficiency syndrome

HEP…….Health extension program

DALY……..….Disability-Adjusted Life Years

HIV……..… Human immune virus

SRH……...….. Sexual and reproductive Health

STDs…….….. Sexually transmitted Diseases

STIs…….……..... Sexually transmitted infections

SPSS…….……..… Statistical Package for Social science

WHO……..……. World Health Organization

ABSTRACT

Introduction: Adolescents' sexual and reproductive health (SRH) is strongly influenced by a range of social, cultural, political, and economic factors and inequalities, which increase adolescents' vulnerability to SRH risks like unsafe sex, sexual coercion, early pregnancy, and pose barriers to their access to SRH information and service. In Ethiopia socio cultural taboos, feel ashamed and lack of communication skill affect adolescent-parent communication on sexual matters. Parents mainly focus on the negative consequence of sexual intercourse. However there is lack of information regarding adolescent-parent communication about SRH matters in the study area.

Objective: the main objective of this study is to assess Parent-Adolescents' Communication on Sexual and Reproductive Health Matters and associated factors among Secondary and Preparatory students

Methods: Institution based cross-sectional study was conducted. Data was collected from students aged 15-19 years old. The data was collected by using structured self-administered questionnaire. The total sample size was 649,calculated by applying single population proportion formulas. Data was cleaned and enteredto EPI info version 7. Descriptive and summary statistics was computed. Pearson chi-square test andbinary (bivariate and multivariate) logistic regression analysis wereapplied to identify determinant factors using SPSS Version 20

Result: Eighty four percent of the study participants reported that it is important to discuss SRH issues with parent/s. However, only 287(44.8%) respondents had discussed at least one SRH issues in the last one year. Discussion on sexual and reproductive health issues among adolescents and their parents was significantly associated with students` age, sex[(AOR = 2.754, (95% CI: 1.746, 4.343)], origin of residence[(AOR= 0.638,(95% CI: 0.410, 0.991)], level of education[(AOR= 2.332, (95%CI: 1.349, 4.034)], 2.456 times [(AOR: 2.456, (95%CI: 1.300, 4.642)] and 4.730 times [(AOR: 4.730,(95%CI: 2.446, 9.146)], type of school[(AOR= 0.321, 95%CI: 0.179, 0.578)] and both parents educational status.

Conclusion: Cultural taboos attached to RH, feeling ashamed and poor parent-child relationship to talk openly and in transparent way remained the major factors for not discussing SRH issues among parents and their young adolescents

Recommendation: Establishing and strengthening youth friendly services, training of RH service providers and concerned bodies, availing necessary materials for RH services, follow-up and integrating adolescent SRH issues with HEP.

1. INTRODUCTION

1.1. Statement of the Problem

Adolescents' sexual and reproductive health (SRH) is strongly influenced by a range of social, cultural, political, and economic factors and inequalities, which increase adolescents' vulnerability to SRH risks like unsafe sex, sexual coercion, early pregnancy, and pose barriers to their access to SRH information and services(1). Unlike most other illnesses and disabilities, sexual and reproductive health problems tend to be masked in embarrassment, secrecy, and shame(2). Many adolescents are unprepared to protect themselves from potentially negative consequences of sexual activity; as a result they are exposed to health risks associated with sexual activity, including STIs, unintended pregnancies, and complications from pregnancy and childbirth. They often have inadequate or misleading information on sexuality and reproductive health and lack access to reproductive health care.(3, 4).

In many part of the world adolescents, girls in particular, are poorly informed about their health, bodies, sexuality and physical well-being as a result of culture and religious sensitivities(5). Adolescent ill health and death constitute a large portion of the global burden of disease. They account for 23% of the overall burden of disease (disability-adjusted life years-DALY) because of pregnancy and child birth (6, 7).

In Africa Many millions of youth suffer from sexually transmitted infections, which can leave young women infertile and, thus, often stigmatized by their communities and families. While they are legally stable many African women marry and give birth before the age of 20. A large proportion of these pregnancies in this age group are unplanned, and many end in unsafe abortion(8).

In Ethiopia socio cultural taboos, feel ashamed and lack of communication skill affects adolescent-parent communication on sexual and reproductive health matters. Parents mainly focus on the negative consequence of sexual intercourse. Despite this many school students begin pre marital sexual activity at their earlier time that might predispose them to different sexual and reproductive health problems.(9-11)

1.2. Literature Review

Sexual and reproductive health is an essential element of good health and human development(12). However, the ability of men and women to achieve this depends on their access to comprehensive good-quality information about sex and sexuality, knowledge about the risks, vulnerability to the adverse consequences of sexual activity, access to good-quality sexual health care, and an environment that affirms and promotes sexual health(13). An increased incidence of HIV infection in adolescents' has led researchers to examine factors that influence young people's sexual behaviors. One of these factors is parent-adolescent communication about sexuality and other reproductive health issues(14). Adolescent-Parent communication on Sexual and reproductive health issues were identified as a means of transmitting sexual values, beliefs, expectations, and knowledge between parents and their children(15). When young people feel unconnected to home, family, and school, they may become involved in activities that put their health at risk, however, when parents affirm the value of their children, young people more often develop positive, healthy attitudes about themselves(16).

1.2.1. Communication between parents and adolescents regarding SRH

The extent to which parents are involved and the manner in which they are involved in their children's lives are critical factors in the prevention of high-risk sexual activity. Children whose parents talk with them about sexual matters or provide sexuality education or contraceptive information at home are more likely than others to postpone sexual activity. And when these adolescents become sexually active, they have fewer sexual partners and are more likely to use contraceptives and condoms than young people who do not discuss sexual matters with their parents, and therefore are at reduced risk for pregnancy, HIV and other sexually transmitted diseases (STDs)(17).

Communications between adolescents and responsible adults on sexuality issues leads to safer sexual practices and prospectively predicts condom use, including consistent condom use(18). Positive communication between parents and children helps young people to establish individual values and make sexually healthy decisions (16)

Inter-generational discussions on sex-related matters are taboo in much of African countries, with some adults believing that informing adolescents about sex and teaching them how to protect themselves would make them sexually active. This also applies in Ethiopia, where parent-youth communication on SRH issues is believed to be culturally shameful (19).

In Ethiopia studies showed that adolescent-parent communication on sexual and reproductive matter is believed that it is important, but the practice is very minimal. Condom use during first intercourse was associated with having communication about sexual and reproductive health issues (9, 10, 19, 20)

1.2.2. Parents Knowledge and attitude towards adolescents' SRH

Parents' own lack of knowledge was noted as a reason for poor parent-adolescent communication. Parents who had been educated at school or been exposed to health promotion messages about SRH would be more likely to discuss these issues with their children (21). The positive effects of parent-child communications appear to be mediated by several critical factors: the frequency and specificity of communications; the quality and nature of exchanges; parental knowledge, beliefs and comfort with the subject matter; and the content and timing of communications (17)

1.2.3. Adolescents source and preference of SRH information

Sexuality education is key in reducing risks and improving adolescent sexual and reproductive health outcomes, however many young people lack adequate knowledge and experience poor access to comprehensive Sexual and Reproductive Health information.(21)

In Ethiopia studies showed that adolescents' most important source of information on sexual and reproductive health were none family members like friends. A study conducted in North West Ethiopia identified that school was mentioned as the most common source of information for SRH issues followed by friends. Another study conducted in Northern part of Ethiopia found media as the most source and preference for sexual and reproductive health information.Parent-adolescent communication was very minimal and only limited topics were being discussed. Studies showed thatmany students prefers their peers than parents to discuss SRH issues (9, 10, 19, 20)

1.2.4. Gender difference in SRH communication

Many parents either do not talk to their children about sex at all or have only limited communication on the topic. How much parents talk about sex and what topics they address have been found to differ substantially by the gender of both the parents and the children. Generally, parents are more likely to talk about sexual topics with the same-sex child: fathers are more likely to talk with their sons than their daughters, and mothers are more likely to talk with their daughters than their sons. However, mothers generally talk more than fathers to both sons and daughters about most sexual topics (3).
Studies in Ethiopia showed that the range of parent-young people communication seems narrow and is limited only to a few topics of reproductive health like HIV/AIDS and abstinence. It also seems gender biased focusing on females and on the importance of virginity and the norm (9, 19, 20)

1.2.5. Adolescents sexual behavior

Although there is no precise age in this respect, it is estimated that the optimum age for becoming sexually active, both in boys and girls, is 18–22 years old. This range reflects the age of physical and mental maturity, although the maturation of the sexual organs begins earlier. The risks of early initiation of sexual activity can be cervical cancer, breast cancer, early aging, infertility and infection with human immunodeficiency virus (HIV) and other sexually transmitted infections (STIs)(22). The health threats for adolescents today are predominantly behavioral rather than biomedical and more of today's adolescents are involved in health behaviors with potential for serious consequences(10). Early sexual activity has clear negative academic consequences for girls when it results in pregnancy, and it predicts lower school performance and expectations for college among girls even in the absence of pregnancy(19). A number of more general indices of family structure and relationship quality also play a role in adolescent sexual behavior. These include family cohesion or closeness; family structure; parenting style, including parental monitoring, supervision or coercion; and general parent-child communication patterns (17). Structural inequities and the social environment place certain groups of adolescents at risk of engaging in behaviors that jeopardize healthy transitions to adulthood(23). In adolescents and young people risky sexual behavior has been recognized as an important health, social and demographic concern in the developing world. Adolescent and youth are vulnerable to many health problems, because they often have multiple sexual relationships and inconsistent use of condoms. Young men may have their first sexual experiences with prostitutes, while young females

may have their first sexual experiences with older men, both of which increase the chance of getting sexually transmitted infections (STIs) including Human Immunodeficiency Virus (HIV)(24). Young people's sexual behavior is influenced by their social and economic context. Aspects of this context that increase or decrease susceptibility of young people to these outcomes includes: gender issues in relationships and families, social norms and poverty(25). Many adolescents become sexually active at an early age when they do not know how to avoid STIs and unwanted pregnancies(7).

In Ethiopia, about 16% of unmarried female youth reported sexual debut, of which 24.6% had two or more sexual partners but only 10% of them used condom during sexual intercourse (26).

1.2.6. Factors affecting adolescent-parent communication about SRH

Inter-generational discussions on sex-related matters are taboo in much of African countries, with some adults believing that informing adolescents about sex and teaching them how to protect themselves would make them sexually active. This also applies in Ethiopia, where parent-youth communication on SRH issues is believed to be culturally shameful (19).

In Ethiopia studies showed that fear of parents, embarrassment, cultural taboos attached to sex, parent failure to give time to listen, family size, and family educational status, adolescents' perceived importance to discussSRH issues with parents, adolescents' ever getting SRH information and parents lack of interest are factors influencing sexual and reproductive health communication among adolescents and their parents.(9, 10, 19, 20, 27)

1.2.7. Conceptual Framework

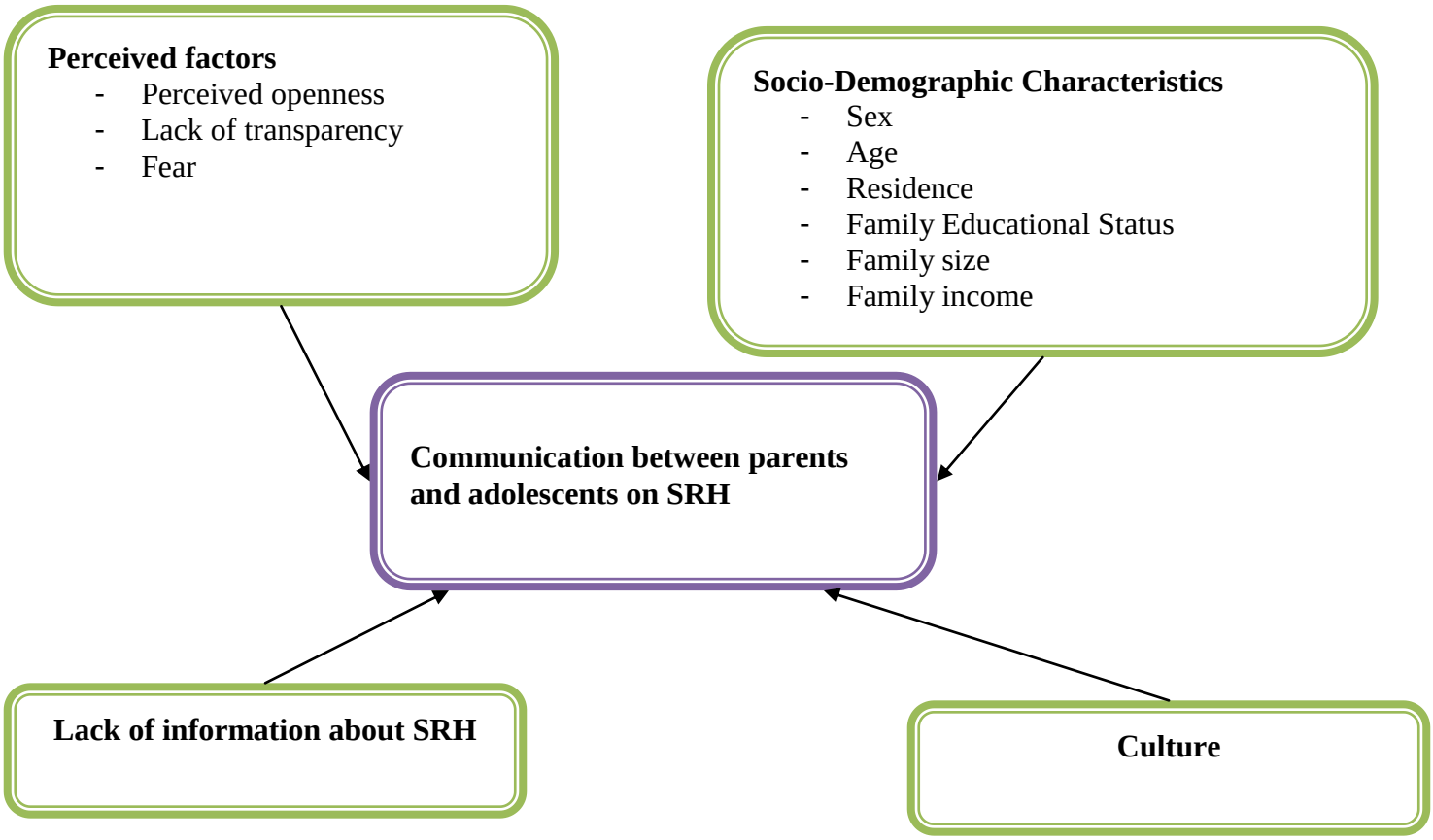

Fig 1: Conceptual frame work of communication between parents and adolescents on SRH adopted after reviewing different literatures.

1.3. Justification of the study

In Ethiopia there are different ethnic groups with their own unique and different culture, norm, believes and religions, which directly or indirectly have effect on adolescents SRH.

In Ethiopia few Studies conducted related to SRH issues showed that adolescent-Parent communication on SRH issues varies from region to region. Even there is a difference from one area to the other in the same region This will be due to difference in knowledge, culture, norms, believes and etc.(9, 10, 20, 24).

In the study area there is lack of information regarding Sexual and reproductive Health communication among adolescents and their parents.. This is a good opportunity to assess factors affecting adolescent-parent discussion regarding SRH issues, so that the findings of the study will help policy makers, program planners and implementers to design evidence based policies, guidelines and interventions to address adolescent Sexual and Reproductive Health issues.

2. Objectives

2.1. General Objectives

The main objective of this study is to assess adolescent-parent communication on sexual and reproductive health matters and related factors influencing their communication

2.2. Specific Objectives

2.2.1. Describe the proportion of students communicating with their parents regarding sexual and Reproductive Health matters.

2.2.2. Identify factors associated with communication among adolescents and parents on sexual and Reproductive Health matters

3. Methods and Materials

3.1. Study Design

Institution based Cross sectional study wasused to conduct the study.

3.2. Study Areaand Period

The study was conducted among secondary and preparatory schools students in Ambo town, Oromiya national regional state from April to June 2015. Ambo is located in the central part of Ethiopia in Oromia National Regional State, at a distance of 114 km from Addis Ababa. According to the Ambo town Population and Housing census carried out in 2007 E.C, the population of the town was 107,980. Out of these 52,912 (49%) were males and 55,068 (51%) were females. Regarding age distribution 16.4% are within the age group of ≥5 years, 31.2% within 6-15 years, 30% within 16-35, 20% within 36-64 years and 2.4 % within 65 and above years of age. There are three preparatory and six secondary schools, ofwhich one preparatoryschool and two secondary schools are owned by private organizations. The rest are public schools. According to Ambo town educational bureau report 14, 600 students were enrolled for 2007 E.C academic year for regular program.Among this 5826(40%) and 8774(60%) are females and males respectively. These Students come from different surroundings of the town and neighboring rural and urban areas with different backgrounds, culture, belief, etc. which they gained, in one way or another, from their parents. This is a good opportunity to assess their relationship with their parents in discussing SRH issues and factors their communication.

3.3. Study population

The study population was all students from grade 9 to 12 attending secondary and preparatory schools in Ambo town during the study period.

3.4. Source population

All students from grade 9-12aged 15-15 years old attending regular school education in secondary and preparatory schools in Ambo town.

3.5. Inclusion Criteria

All regular students who are unmarried and whose age is between 15-19 years attending secondary and preparatory schools in the study area were included.

3.6. Sample Size and Sampling procedure

3.6.1. Sample size determination

The sample size was determined using single population proportion formula considering the following assumption.

P = 43.5% (proportion of students communicating on SRH issues with parents which is taken from previous study (19)

Significance level 95% (α = 0.05), and Z α/2 = 1.96

Margin of error 4% (D = 0.04).

The formula for calculating the sample size where N <10,000 (N =6001) is:

$$n = \frac{(Z\frac{\alpha}{2})^2 P(1-P)}{d^2}$$

Thus a minimum of 590 adolescents (both male and female) was the required number in the study. For possible none response rate the sample size was increased by 10%. The final sample size was 649.

3.6.2. Sampling Procedure

Stratified systematic random sampling technique was applied to include all schools in the study. First schools were stratified to grades 9, 10, 11 and 12. Then proportional allocation of sample size was used to determine number of students who will participate in the study from each stratum. The number of study subjects from each grade was allocated proportionally based on the number of students in each grade. Again the same allocation of sample size was used for the same grades found in different schools. Systematic random sampling was used to select number of students from each section. List of students in each section was used as a sampling frame. Schematic presentation of sampling procedure is shown below.

One preparatory and one secondary school were excluded during data collection. These schools are found in prison. Many of them do not fulfill the inclusion criteria.

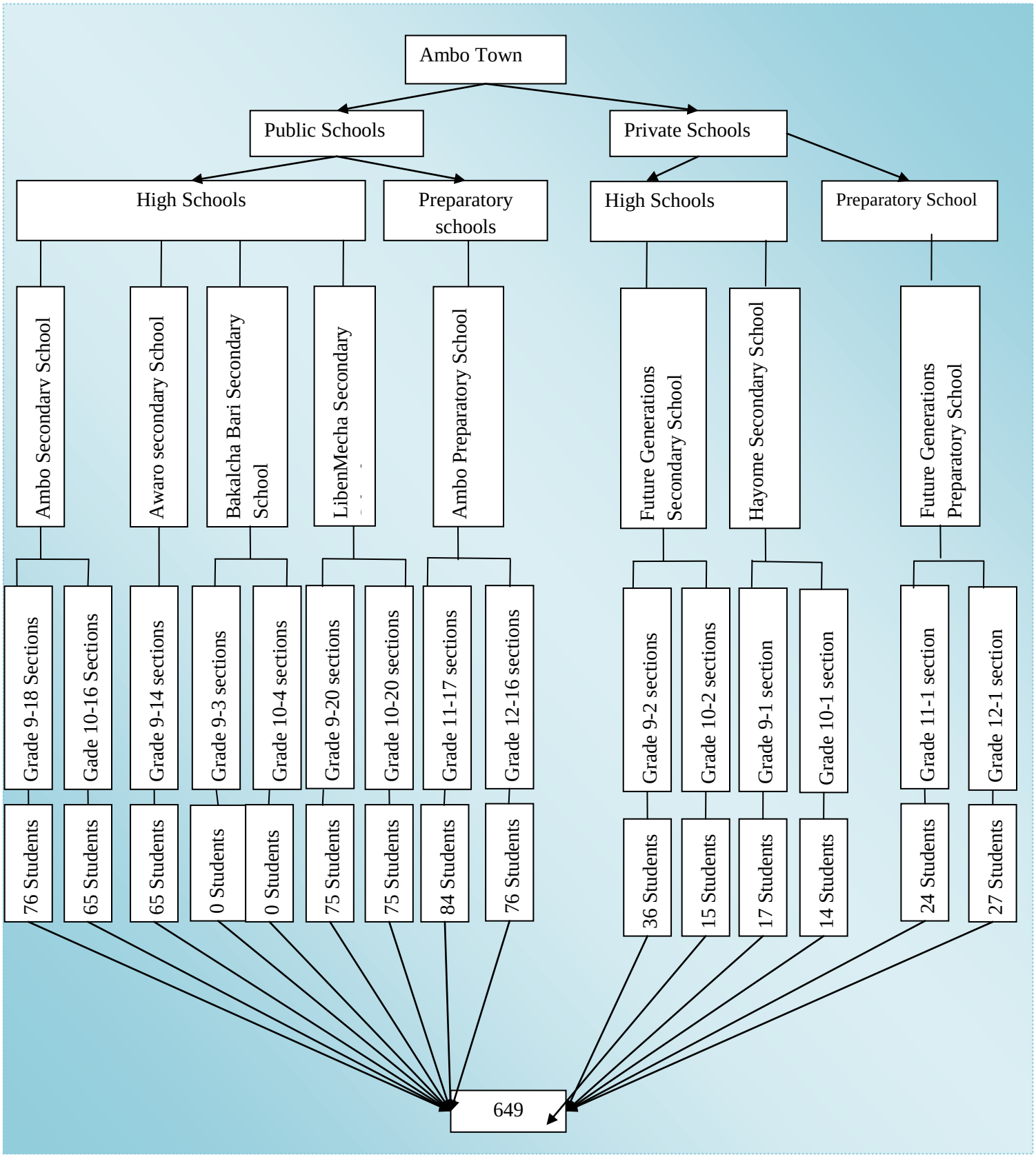

Figure 2: Schematic presentation of sampling procedure

3.7. Variables of the Study

3.7.1. Dependant Variable

SRH Communication

3.7.2. Independent Variables

- **Socio-demographic variables**
    - Age
    - Sex
    - Religion
    - Ethnicity
    - Residency
- **Parent factors**
    - Mother`s educational status
    - Father`s educational status
    - Mother`s occupation
    - Father`s occupation
- **Living arrangement**
- **Student`s level of education**
- **Type of school**

3.8. Operational Definition

1. **SRH Communication**: in this study students who had discussed at least one SRH issues (Body change during puberty, Menstruation, Abstinence, Condom use, Family planning, STIs including HIV, Unwanted pregnancy, Abortion ,Sexual Relationship with opposite Sex, Safer sex practice/Negotiation, VCT) with their parents in the last 12 monthswere considered as having SRH communication
2. **Parents**: in this study parents means biological parents and elderly siblings

3.9. Data Collection Procedures

Data was collected using pre tested self-administered questionnaire which was adopted by reviewing different literatures on similar topic. The questionnaire contains 3 parts, part 1 Socio-demographic characteristics, part 2 sexual behaviors of students and part 3 Source of information and adolescents' views about parent- adolescent communication on sexual and reproductive health issues. The questionnaire was prepared in English language and translated to a local language, Afan Oromo, for appropriateness and easiness. The Afan Oromo version of the questionnaire was translated back to English to check for consistency of meanings. Translation was made by language expert. The questioner was pretested on 5% of the sample size, which were 32 studentswho were not included in the study to ensure its completeness and consistency to provide the information needed.After pretest an important modification was made to the questionnaire and the final version of the questionnaire was used for data collection.

3.10. Data Processing and analysis

Each questionnaire was checked for completeness and errors in coding manually during data collection and before data entry. Then, data was checked, coded and entered to Epi-info version 7 and exported to SPSS version 20 for analysis. Chi-square test and binary (bivariate and multivariate) logistic regression techniqueswere applied to test an association between dependent and independent variables. Most of the variables were fitted to the bivariate logistic regression.The variables were also examined in the multivariate analysis in order to identify the significant predictors of SRH communications after controlling for other variables. Crude and adjusted Odds ratios with their 95% confidence intervals werealsocomputed. A p-value of less than 0.05 was considered as statistically significant

3.11. Data Quality Control

Two data collectors and one coordinator, having previous experience were recruited for data collection process. The data collectors were one midwifery nurse and one clinical nurse who have previous data collection experience. The coordinator was a teacher working outside of the schools data was collected and he has previous experience in coordinating such activity. To maintain data quality, two days training was given for data collectors and the coordinator by the principal investigator. Objectives of the study, contents of the questionnaire, ways of data collection, data quality and confidentiality issues were some of the topics covered during the training. Data collectors were supervised by the principal investigator and the coordinator. Onsite technical assistance and guidance was given by the researcher. Problems faced during data collection were solved on times.

4. Ethical Consideration

Ethical clearance was obtained from Ethical review committee of university of Gondar for the study. A formal letter was written from school of public health, University of Gondar. Respectively permission from Ambo town educational bureau was secured. Then oral consent was obtained from the study subjects after explaining the study objectives and procedures and their right to refuse to participate in the study any time they want. For this purpose a consent letter was attached to the cover-page of each questionnaire stating about the general purpose of the study and issues of confidentiality which was discussed by data collectors and principal investigator before proceeding to data collection [Annex 1].There was no personal identification on the questionnaire and the collected data was kept with the principal investigator to ensure anonymity and confidentiality.

5. Results

5.1. Socio-demographic characteristics of respondents

A total of 649 students attending secondary and preparatory schools in the study area were contacted to take part in the study. Six hundred forty (640) participants completed the questionnaire,making a response rate of 98.6%. Nine students refused to respond to the questionnaire making a non-response rate of 1.4%. Out of the 640 students who responded to the questionnaire 309(43.3%) were males and 331(51.7%) were females. The mean age of the respondents` was 17.21years (SD= 1.305), age group ranging from 15-19 years. The majority of the students, 338(52.8%), were originally from urban areas. Among all respondents 506(79.1%) were attending their education in public schools. Majority 600(93.8%) of the respondents were ethnically Oromo. Most 304(47.5%) of the respondents, were followers of Orthodox Christianity. Three hundred seventy three, (58.3%), of respondents were currently living with their both. Sixty seven, 10.5%, of the respondents were living only with their mothers [Table 1]

One hundred fifty seven (24.5%) of the study participant`s mothers can`t read and write as compared to only 89(13.5%) their fathers who can`t read and write. 225(35.1%) of study participants fathers were at tertiary level of education. 216 (33.8%) of respondents` fathers are employed and 128(20%) of them run their own business

133(20.6%) of study participants` mothers were at tertiary level of education and 136(21.3%) of them were house wife. 147(23%) of them were employed and 145(22.7%) run their own business [Table 2]

Table 1: Socio demographic characteristics ofSchools' Students, Ambo Town, Oromiya Region, Ethiopia, 2015 (n=640)

Variable	Frequency	Percent
Sex		
Male	309	48.3%
Female	331	51.7%
Age		
Mean	17.21(SD= 1.305)	
Original Residence		
Urban	338	52.8%
Rural	302	47.3%
Religion		
Orthodox	304	47.5%
Protestant	281	43.9%
Muslim	11	1.7%
Catholic	12	1.9%
Other*	32	5.0%
Ethnicity		
Oromo	600	93.8%
Amhara	26	4.1%
Tigrie	7	1.1%
Gurage	7	1.1%
Level of Education		
Grade 9	220	34.4%
Grade 10	200	31.3%
Grade 11	112	17.5%
Grade 12	108	16.8%
Type of School		
Public	506	79.1%
Private	134	20.9%
Living arrangement		
With Both parents	373	58.3%
With Mother only	67	10.5%
With Father only	5	0.8%
Others**	195	30.5%

-Others*= indicate Wakefata and Adventist

-Others**= indicates those who is living with Relatives, friends or Alone

Table 2: Socio-demographic characteristics of study participants' parents, Ambo Town, Oromiya Region, Ethiopia, 2015, n=640

Variable	Frequency	Percent
Mother`s Educational Status		
Can`t read and write	157	24.5%
Read and write only	142	22.5%
Primary Education	82	12.8%
Secondary Education	95	14.8%
Tertiary Education	133	20.8%
Other*	31	4.8%
Father`s Educational Status		
Can`t read and write	89	13.9%
Read and write only	109	17%
Primary Education	61	9.5%
Secondary Education	98	15.3%
Tertiary Education	225	35.1%
Other**	58	9.1%
Mother`s Occupation		
House wife	136	21.3%
Daily laborer	19	3.0%
Farmer	175	27.3%
Employed	147	23.0%
Own business	145	22.6%
Other*	18	2.8%
Father`s Occupation		
Daily laborer	33	5.2%
Farmer	210	32.8%
Employed	216	33.8%
Own business	128	20%
Other**	53	8.3%

-Other* indicates students whose mother are not alive

-Other** indicates students whose father are not alive

5.2. Communication between parents and adolescents regarding SRH

The study participants were asked about the importance of discussing SRH issues with parents. Five hundred forty, 84.4%, of the respondents reported that it is necessary to discuss SRH issues with parents.Among all the respondents 287(44.8%) of them had discussion about SRH issues with their parents in the last one year. Among these 114(39.7%) and 173(60.3%) are males and females respectively. [Table 3]

Table 3: **Frequency Distribution of Students who discussed SRH issues with their parents, Ambo Town, Oromiya Region, Ethiopia, 2015, n=287**

Variable	Frequency	Percent
Sex		
Male	146	39.7%
Female	141	60.3%
Age in years		
15	19	6.6%
16	35	12.2%
17	65	22.6%
18	92	32.1%
19	76	26.5%
Residence		
Urban	183	63.8%
Rural	104	36.2%
Religion		
Orthodox	133	46.3%
Protestant	128	44.6%
Others*	26	9.0%
Level of Education		
Grade 9	54	18.8%
Grade 10	106	40.0%
Grade 11	58	20.2%
Grade 12	69	24.0%
Type of school		
Public	237	82.6%
Private	50	17.4%
Mother`s Educational Status		
Can`t read and write	35	12.2%
Read and write only	53	18.5%
Primary Education	30	10.5%
Secondary Education	49	17.1%
Tertiary Education	114	39.7%
Other*	6	2.1%
Father`s Educational Status		
Can`t read and write	13	4.5%
Read and write only	37	12.9%
Primary Education	31	10.8%
Secondary Education	42	14.6%
Tertiary Education	156	54.4%
Other**	8	2.8%

-Other*=indicates those with no mother but have communicated SRH issue with parents

-Other** = indicates those with no father but have communicated SRH issue with parents

5.3. SRH topics discussed among adolescents and their parents

The most discussed SRH related topic among study participants was family planning followed by STI including HIV and body change during pregnancy. The list topics discussed were Sexual partner and safe sex practice.

Table 4**: Topics discussed among study participants and their parents Ambo Town, Oromiya Region, Ethiopia, 2015, n=287**

SRH Topics discussed	Frequency (%)*
Body change during puberty	72(11.2%)
Menstruation	77(12.0%)
Abstinence	21(3.3%)
Delay initiation of sexual intercourse	31(4.8%)
Condom use	26(4.1%)
Family planning	81(12.7%)
STIs including HIV	78(12.2%)
Unwanted pregnancy	32(5.0%)
Abortion	12(1.9%)
Sexual partner	9(1.4%)
Safer sex practice/Negotiation	9(1.4%)
VCT	55(8.6%)

*=Multiple responses were possible

5.4. Adolescents source and preference of SRH information

The most frequently mentioned source of SRH information was TV 365(57%) followed by school 345(53.9%). (Table 5)

Table 5: Source of information for SRH issues mentioned by study participants

SRH Source of information N=640	Frequency*
TV	365(57.0%)
Radio	217(33.9%)
Magazine	171(26.7%)
Parents	212(33.1%)
School	345(53.9%)
Friends	235(36.7%)
Health Workers	243(38.0%)

*=Multiple responses were possible

5.5. Adolescent's preference for discussion of SRH issues.

Among the 287 participants who reported having SRH issues with their parents 329(51.4%) of them reported that they prefer to have SRH with their friends followed by 189(29.5%) who prefer their mother for SRH discussion. [Table 7]

Table 6: Adolescents preferences for SRH Communication

Variable	Frequency	Percent
Mother	189	29.5%
Father	60	9.4%
Brother	92	14.4%
Sister	121	18.9%
Teachers	47	7.3%
Friends	329	51.4%
Health workers	151	23.6%

5.6. Factors affecting adolescent-parent communication about SRH

Eight four percent of the study participants reported that it is important to discuss SRH issues with parent. However, only 287(44.8%) respondents had discussed at least one SRH issue. Out of the three hundred fifty three students who reported that they never discussed SRH issues with their parents 133(20.8%) of them reported that poor parent adolescent relationship and perceived openness about SRH issues were their major reasons for not discussing. One hundred six, 16.6%, students reported that their reason as it is shame full to talk or discuss SRH issue with parents. (Table 6)

Table 7: Factors affecting adolescent-parent RH communication mentioned by study participants

Reasons for not discussing SRH issues	Frequency	Percent
Culturally not acceptable	49	7.7%
It is shameful	106	16.6%
Parent`s lack of knowledge	58	9.1%
Parent`s lack of communication skills	133	20.8%
Parent`s are not good listeners	15	2.3%
Parents are busy	38	5.9%

Pearson chi-square test and both binary and multivariate analysis were also doneto identify factors associated with adolescent-parent communication on Sexual and reproductive health issues. As shown in table 8 below, discussion on sexual and reproductive health issues among adolescents and their

parents was significantly associated with students` age, sex, origin of residence, level of education and both parents educational status. Type of school (Private or public) and students' sexual exposure also has a significant association with SRH communication. However, religion, Ethnicity, living arrangement and parents` occupation were found to be insignificant in both binary and multivariate logistic regression analysis.

The odds of female students to discuss SRH issues with their parents were 2.754 times [(AOR = 2.754, (95%CI: 1.746, 4.343)] higher than that of male students. In other case, the odds of rural students to discuss SRH issues with their parents was 36.2% times [(AOR= 0.638,(95% CI: 0.410, 0.991)] less as compared to urban students.

The odds of students of grade 10, 11 and 12 to discuss SRH issues with their parents were 2.332 times [(AOR= 2.332, (95%CI: 1.349, 4.034)], 2.456 times [(AOR: 2.456, (95%CI: 1.300, 4.642)] and 4.730 times [(AOR: 4.730,(95%CI: 2.446, 9.146)] respectively, higher than that of students in grade 9. This indicates that as students were progressing with their education, the probability of discussing SRH issues with their parents will increase. The odds of students attending their education at private schools to discuss SRH issues with their parents 67.9% times [(AOR= 0.321, 95%CI: 0.179, 0.578)] less as compared to students attending their education at public schools.

Students whose mothers are able to read and write only are 1.919 times [(AOR= 1.919,95% CI:1.040, 3.540)] higher than that of students whose mothers can`t read and write to discuss SRH issues with their parents. Students whose mothers were at secondary education, diploma and degree and above educational status were 2.942, 8.510 and 46.494 times more than that of students having mothers who cannot read and write respectively, to discuss SRH issues with their parents.But, there are no significant differences in discussing SRH issues with their parents between students whose mothers are at primary educational level and whose mothers can`t read and write.

Students whose fathers were able to read and write only were 4.241 times [(AOR: 4.241, 95%CI: 1.768, 10.173)] higher than that of students whose fathers can`t read and write. Students having fathers who are at primary, secondary, diploma and degree and above educational level were 7.168, 5.178, 9.747 and 12.458 times more than that of students having fathers who can`t read and write respectively, to discuss SRH issues with their parents. But, there is no significant differences in discussing SRH issues with their parents between students having fathers that can`t read and write and students have no fathers.

Finally, the odds of students who have no sexual exposure was 61.6 % times less than that of students who have sexual exposure to discuss SRH issues with family. Finally, the rate of students to discuss SRH issues with their parents was increased by 0.491 as the age of students is increased by one

Table 8: Factors affecting adolescent-parent communication about SRH

Variable		Discussed SRH issues		COR [95% C.I.]	AOR [95% C.I.]	P-value
		Yes	No			
Sex						
	Female	114	195	1.873 [1.365, 2.569]	2.754 [1.746, 4.343]	.000*
	Male	173	158	1		
Original Residence						
	Rural	183	155	0.445 [0.323, 0.612]	0.638 [0.410, 0.991]	.046*
	Urban	104	198	1		
Level of Education						
	Grade 10	54	166	3.467 [2.291, 5.244]	2.332 [1.349, 4.034]	.002*
	Grade 11	106	94	3.302 [2.040, 5.343]	2.456 [1.300, 4.642]	.006*
	Grade 12	58	54	5.439 [3.304, 8.953]	4.730 [2.446, 9.146]	.000*
	Grade 9	69	39	1		
Type of School						
	Private	237	269	0.676 [0.457, 0.999]	0.321 [0.179, 0.578]	.000*
	Public	50	84	1		
Mothers Educational Status						
	Read and write only	35	122	2.076 [1.250, 3.446]	1.919 [1.040, 3.540]	.037*
	Primary education	53	89	2.011 [1.119, 3.613]	1.728 [0.856, 3.489]	.127
	Secondary education	30	52	3.713 [2.141, 6.439]	2.942 [1.473, 5.876]	.002*
	Diploma	49	46	10.95 [5.390, 22.264]	8.510 [3.482, 20.803]	.000*
	Degree and above	44	14	48.8 [18.278, 130.29]	46.49 [14.45, 149.54]	.000*
	Can`t read and write	6	25	1		
Fathers Educational Status						
	Read and write only	13	76	3.004 [1.478, 6.107]	4.241 [1.768, 10.173]	.001*
	Primary education	37	72	6.041 [2.788, 13.090]	7.168 [2.715, 18.920]	.000*
	Secondary education	31	30	4.385 [2.153, 8.931]	5.178 [2.130, 12.587]	.000*
	Diploma	42	56	10.23 [4.723, 22.163]	9.747 [3.800, 25.001]	.000*
	Degree and above	42	24	14.81 [7.488, 29.292]	12.158 [5.212, 28.36]	.000*
	Can`t read and write	8	50	1		
Sexual Exposure						
	No	71	53	0.537 [0.362, 0.799]	0.384 [0.225, 0.655]	.000*
	Yes	216	300	1		
Age		287	353	1.551 [1.363, 1.765]	1.634 [1.354,1.972]	.000*

6. Discussion

This study attempted assessed adolescent-parent communicationonSRH, frequency of their discussion, source of information for SRH, preference of adolescents to discuss SRH issues, adolescents' views about the importance of communicating parents about SRH issues, persons involved in their communication other than family members and associated factors based on cross sectional data collected from 640 secondary and preparatory schools students in Ambo town. This study is one of the few studies conducted in Ethiopia to assess adolescent-parent communication about SRH issues.The results of this study revealed that 287(44.8%) of the study participants had ever discussed at least one SRH topic with their parents. Whereas, about 353(55.2%) of the respondents had no discussion about SRH issues their parents. Discussion on SRH issues among adolescents and their parents was significantly associated with students` age, sex, origin of residence, level of education and both parents educational status. Type of school (Private or public) and students' sexual exposure also has a significant association with SRH communication. However, religion, Ethnicity, living arrangement and parents` occupation were found to be insignificant in both binary and multivariate logistic regression analysis.

In this study 287(44.8%) adolescents reported that they ever discussed at least one SRH topic with their parents during their life time. This finding is higher as compared with study done in BenishangulGumuz,(North West Ethiopia), Diredawa, (Eastern Ethiopia), Mekele, (Northern Ethiopia)Debre Markos town, North West Ethiopia and East Wollega, (Western Ethiopia), were the proportion of students who discussed SRH issues with their parents was 28.9%, 37%,43.5%,36.9% and 32.5% respectively.(9, 10, 19, 20)

This study identified that parents` lack of transparency and openness to talk about sexual and reproductive health issues with their children as a major reason for no discussing SRH issues with their young children.

This study showed that female students have discussed SRH issues with their parents more than that of male students. This finding is consistent with the study conducted in Dire Dawa. However this finding contradicts with the finding of a study conducted in East wollega, Western Ethiopia were more males (44.2%) than females (41%) reported to have ever had engaged in conversation with their parents/parent figures on topics SRH.(9, 20).

In this study it was found that rural students discussed SRH issues with their parent'sless than urban students. This might be due to lack of targeted reproductive health services for the rural adolescents. This result is consistent with a study conducted in EastWollega, Western Ethiopia (20)

This study revealed that as students' level of education increases the probability of discussing SRH issues with parents will increase. This result is consistent with a study conducted in East Wollega, Western Ethiopia. But, this result contradicts with study in Debre Markos, North West Ethiopia, were grade 12 students were less likely to communicate their parents with regard to SRH as compared to grade 9 students.(20, 28)

This study found that that as age of students` increase the probability of students to discuss SRH issues with their parents will increase.(20)

This study found that students attending their education at private schools were less likely to discuss SRH issues with their parents as compared with students attending their education at public schools. This study revealed that as parental education increases the probability of students to discuss SRH related issues will increase. This is due to the fact that, educational status can help an individual to understand their children to discuss SRH and other issues better. This result is consistent with the study conducted in Dire Dawa, East Wollega, and Mekele.(9, 19, 20)

This study found that student who had ever got any sort of information from different sources were more likely to discuss SRH related issues with their parents. This result is consistence with a study done in Debre Markos,North West Ethiopia.(28)

7. Conclusion

This study finding showed that eight four percent, 504, of the study participants reported that it is important to discuss SRH issues with parents. However, only 287(44.8%) respondents had discussed at least one SRH issue throughout their life time. The respondents preferred source of information for SRH was non family source. Discussion on SRH issues among adolescents and their parents was significantly associated with students` age, sex, origin of residence, level of education and both parents educational status. Type of school (Private or public) and students' sexual exposure also has a significant association with SRH communication. Source of information for SRH was also has an association. However, religion, Ethnicity, living arrangement and parents` occupation were found to be insignificant in both binary and multivariate logistic regression analysis. Cultural taboos attached to RH, felled ashamed, parents lack of knowledge about SRH matters and poor parent-child relationship to talk openly and in transparent way remained the major factors for not discussing sexual and reproductive health issues among parents and their young adolescents

8. Recommendation

For Zonal Health Office

- Strengthening youth friendly services at each health facility
- Training school staffs to equip them on necessary RH knowledge and skill

For Zonal education office

- Establishing youth friendly services at each school
- Providing necessary materials for RH related services
- Follow-up of the services

For Zonal Administrative bodies

- Strengthening RH services targeting adolescents through HEP to promote adolescent-parent communication on SRH.
- Follow-up

9. Strength and limitation of the study

Strength

- Identified factors associated with adolescent-parent communication on SRH issues

Limitation

- Quantitative only-If mixed method(Addition of FGD) is better
- It may be difficult to generalize results to adolescents in other institutions and localities because of differences in socio-demographic, culture, educational status and life styles.
- The study included only in school adolescents
- Since it is cross sectional study causal effect relationship could not be established

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11.Annexes

ANNEX 1: Information Sheet and Consent Form

Title of the Research Project: Assessment of Parent-Adolescents' Communication on Sexual and Reproductive Health Matters and associated factors among Secondary and Preparatory Schools' Students in Ambo Town, Oromiya Region, Ethiopia

Name of Investigator: Demisew Beyene (RN, BA)

Name of the Organization: University of Gondar College of Medicine and Health Sciences,

School of Public Health

Introduction

My name is _____. I am working as data collector in a survey to be conducted by an MPH candidate in University of Gondar to assess Parent-child Communication on Sexual and reproductive Health issues and related factors

This questionnaire is prepared for collecting information on Adolescent-Parent Communication on Sexual and Reproductive Health issues and related factors among Ambo Secondary and Preparatory schools.

Purpose of the Research Project

The aim of this study is to assess adolescent-parent communication on sexual and reproductive health matters and related factors influencing their communication, so that the findings of the study will help policy makers, program planners and implementers to design evidence based policies, guidelines and interventions to address adolescent Sexual and Reproductive Health issues.

Procedure

In order to conduct this study I invite you to take part in this study. If you are willing to participate in the study, you need to understand the purpose of the study and give verbal consent. Then; you will be requested to give your response to the data collectors.

Risk and /or Discomfort

By participating in this study you may feel some discomfort especially on your time (about 15-20 minutes) otherwise, no risk in participating in this study and this may not be too much as you are one of the students in the study area, so your response provide an important input to show the gap and means to improve parent-adolescent communication on sexual and reproductive health issues.

Benefits

If you are participating in this study, the output of the study will have both direct and indirect benefit to you, but your participation is likely to help in showing the factors associated with parent-adolescent communication on sexual and reproductive health issues. You will not be provided any incentives or payment to take part in this Study.

Confidentiality

Your answers are completely confidential, your name will not be written on this form, and will never be used in connection with any of the information you tell me. The information collected will be kept confidential and stored in a file, without your name, but a code number assigned to it. It will not be revealed to anyone except the principal investigator.

Right to Refuse or Withdraw

You have full right to refuse from participating in this research. You do not have to answer any questions that you do not want to answer and you may end filling of the questionnaire at any time you want. However, your honest answers to these questions will help us better understand about factors affecting Parent-Adolescent communication on sexual and reproductive Health issues. I would greatly appreciate your participation

Person to contact

This research project will be reviewed and approved by the ethical committee of the University of Gondar. If you have any question you can contact any of the following individuals.

1. Demisew Beyene (Principal Investigator): Cell phone +251911181721.
   E-mail: demisew_2007@yahoo.com.
2. Mr. ResomBerhe :School of public health, University of Gondar
   Cell phone: +251912352681
3. Mr. EndalewGemechu: Addis Ababa University, College of Health Science, School of Nursing and Midwifery, Addis Ababa, Ethiopia
   Cell phone: +251911196298

ANNEX 2: English version of the questionnaire

Instruction

1. Circle the answer that you think is correct(in some cases more than one answer is possible)
2. You should fill the questionnaire individually and discussion is not allowed.
3. If there is any problem in understanding the questions, you can ask data collectors for help.

Part 1:Socio-demographic characteristics			
SN	Questions	Response	Skip
101	Identification	_____	
102	Age	_____ Years	
103	Sex	1. Male 2. Female	
104	Original Residence	1. Urban 2. Rural	
105	Religion	1. Orthodox 2. Protestant 3. Muslim 4. Catholic 5. Other(Specify)_____	
106	Ethnicity	1. Oromo 2. Amhara 3. Tigrie 4. Gurage 5. Other (Specify)_____	
107	Your level of education	1. Grade 9 2. Grade 10 3. Grade 11 4. Grade 12	
108	Type of School	1. Public 2. Private	
		1. Both parents	

109	Currently living with	2. Mother only 3. Father only 4. Relatives 5. With friends 6. Alone 7. Other(Specify)_____	
110	Mother's educational status	1. Can`t read and write 2. Read and write only 3. Primary school 4. Secondary school 5. Diploma 6. Degree and above 7. No mother	
111	Father`s educational status	1. Can`t read and write 2. Read and write only 3. Primary school 4. Secondary school 5. Diploma 6. Degree and above 7. No father	
- 112	Mother's Occupation	1. House wife 2. Daily laborer 3. Farmer 4. Employed 5. Own business 6. No mother	
113	Father`s Occupation	1. Daily laborer 2. Farmer 3. Employed 4. Own business 5. No father	
Part 2: Adolescents Sexual Behavior			

201	Have you ever had sexual intercourse?	1. Yes 2. No	If no skip to Question301
202	Age at first sex (if yes)	_____ Years	
203	Where did you start sex?	1. At primary School 2. At Secondary School	
204	With whom did you have sex first?	1. Boy/girl friend 2. Teacher 3. Older person(for female respondent) 4. Commercial sex worker (male respondent) 5. Unknown person 6. Others (specify)_____	
Part 3: S**ource of information and Adolescents' views about Parent- Adolescent Communication on sexual and Reproductive Health issues**			
301	Where did you get information about sexual and reproductive health issues? (Multiple responses possible)	1. TV 2. Radio 3. Magazine 4. Parents 5. School 6. Peers 7. Health works 8. Others(Specify)_____	
302	Is it important to discuss sexual and reproductive health matters with Parent/s?	1. Yes 2. No	
303	Have you ever discussed sexual and reproductive health issues with your parent/s?	1. Yes 2. No	If no skip to question 307

304	Which sexual and reproductive health topic/s have you discussed with your parents in the last 1 year? (More than one answer is possible)	1. Body change during puberty 2. Menstruation 3. Abstinence 4. Delay initiation of sexual intercourse 5. Condom use 6. Family planning 7. Sexually Transmitted Infections(STIs) including HIV 8. Unwanted pregnancy 9. Abortion 10. Sexual partner 11. Safer sex practice/Negotiation 12. Voluntary Counseling and Testing(VCT)	
305	How frequent you have discussed?	1. Very often 2. Often 3. Sometimes	
306	If you have ever discussed at least one of the above topics with your parents, at what age have you started discussing it?	_____age in years	
307	With who have you discussed other than your parent/s?	1. Health workers 2. Teachers 3. Friends 4. With no one 5. Other(Specify)_____	
308	Whom do you prefer to get information about sexual and reproductive health issues? (Multiple responses is possible)	1. Mother 2. Father 3. Brother 4. Sister 5. Teachers 6. Friends	

		7. Health workers 8. Other (Specify)_____	
309	At what age do you think discussion on sexual and reproductive health issues should be started between adolescents and their parents?	_____Age in years	
310	If you didn't discuss sexual and reproductive health issues with your parents, what was/were your major reason(s) for not discussing? (Multiple responses are possible)	1. Culturally not acceptable 2. It is shameful 3. Parent`s lack of knowledge about SRH 4. Parent`s lack of transparency to discuss SRH issues 5. Parent`s are not good listeners 6. Parents are busy 7. Other (Specify)_____	
311	Would you encourage a friend to discuss sexual and reproductive health issues with parents?	1. Yes 2. No	

Thank You!!!

Annex 3: Afan Oromo Version of the Questionnaire

Bargaaffiin kun odeeffannoo waa`ee walitti dhufeenya dargaggeeyyii fi maatii isaanii waa`ee Sirna fayyaa walhormaata aakkasumas dhimmoota walfakkaatan irratti barattoota manabarumsaa Amboo sadarkaa 2^{ffaa} fi qophaa`inaa irraa odeeffannoo funaannachuuf kan qophaa`e dha.

Qajeelcha

1. Deebiisirriidhajettuittimari(iddootokkotokkottideebiintokkoolnidanda`ama)
2. Bargaaffii kana qofaakeeguutuuqabda. Namabiraawaliinmarii`achuunhindanda`amu
3. Gaaffiiwwanhubachuurrattiyoorakkinnisimudategaafachuunidandeessa.

Kutaa 1^{ffaa}: Gaaffiiwaa'eejireenyahawaasummaa			
Lakk.	Gaaffiiwwan	Deebii	Darbi
101	Koodii	_____	
102	Umurii	Waggaa _____	
103	Saala	1. Dhiira 2. Dubara	
104	Bakkairraadhufte	1. Magaala 2. Baadiyaa	
105	Amantii	1. Ortoodoksii 2. Protestaantii 3. Islaama 4. Kaatolikii 5. Kanbiraayoojiraateibsi_____	
106	Sabummaa	1. Oromoo 2. Amaara 3. Tigiree 4. Guraagee 5. Kanbiraayoojiraateibsi____	
107	SadarkaaBarnootakee	1. Kutaa 9^{ffaa} 2. Kutaa 10^{ffaa} 3. Kutaa 11^{ffaa} 4. Kutaa 12^{ffaa}	

108	ManaBarumsaaittibarattu	1. KanUummataa 2. KanDhuunfaa	
109	Yerooammaakanjiraattueenyufaana?	1. Haadhaa fi abbaaWaliin 2. Haadhaqofaa 3. Abbaaqofaa 4. Firawaliin 5. Hiriyyaawaliin 6. Qofaa 7. Kanbiraayoojiraateibsi_____	
110	Sadarkaabarumsaahaadhakee	1. Dubbisuu fi barreessuuhindandeessu 2. Dubbisuu fi barreessuuqofaadandeessi 3. Barnootasadarkaa 1ffaa 4. Barnootasadarkaa 2ffaa 5. Dippiloomaa 6. Digirii fi isaaol 7. Haatilubbuunhinjirttu	
111	Sadarkaabarumsaabbaakee	1. Dubbisuu fi barreessuuhindandeessu 2. Dubbisuu fi barreessuuqofaadanda`a 3. Barnootasadarkaa 1ffaa 4. Barnootasadarkaa 2ffaa 5. Dippiloomaa 6. Digirii fi isaaol 7. Abbaanlubbuunhinjiru	
112	Hojiihaaadhakee	1. Haadhamanaa 2. Hojjettuuguyyaa 3. Qonnaanbulttuu 4. Qacaramtuu 5. Hojiidhuunfaasheekanhojjettu	

		6. Haatilubbuunhinjirttu	
113	Hojiiabbaakee	1. Hojjetaaguyyaa 2. Qoteebulaa 3. Qacaramaa 4. Hojiidhuunfaasaakanhojjetu 5. Abbaanlubbuunhinjiru	
Kutaa 2ffaa : AmalaSaalquunnamtii			
201	Walquunnamtiisaalaaraawwatteebeektaa?	1. Eeyyee 2. Lakki	Yoolak kijette 301 ttidarbi
202	Deebiinkeeeeyyeeyoota`eumuriiwaggaameeqaffaatti?	Waggaa _____ tti	
203	Walqunnamtiisaalaaraawwachueessattieegalte?	1. Manabarumsaasadarkaa 1ffaatti 2. Manabarumsaasadarkaa 2ffaattti	
204	Yeroojalqabaafwalqunnamtiisaalaakanraawwatteeenyufaana?	1. Hiriyyaadhiiraa/ dubaraawaliin 2. Barsiisaa / Barsiisttuuwaliin 3. Namaumuriidhaansiinolii(Shamarraaf) 4. Dubartootamanabunaa (Dhiiraaf) 5. Namahinbeeknefaana 6. Kanbiraayoojiraateibsi_____	
Kutaa 3ffaa: Maddaodeeffannoo fi ilaalcha/hubannoodargaggootaawaa`eeSirnafayyaawalhormaatamatiiisaaniiwaliinqabanii fi sababootaisaanii			
301	Odeeffannoowaa`eesirnafayyaawalhormaataaeessaargatta? (Debiintokkooolnidanda`ama)	1. Televiziniiirraa 2. Raadiyooirraa 3. Baruuleeirra 4. Maatiiirra 5. Manabarumsaa 6. Hiriyyootairraa	

		7. Ogeessafayyaairraa 8. Kanbiraayoojiraateibsi___ _____	
302	Waa`eesirnafayyaawalhormaataamaatiiwajjinmari`achuunbarbaachisaadhajetteeyaaddaa?	1. Eeyyee 2. Lakki	
303	Waa`eesirnafayyaawalhormaataamaatiikeewaliinmarii`atteebeektaa?	1. Eeyyee 2. Lakki	Yoolakki jette 307 ttidarbi
304	Yeroodhiyoottimatadureesirnafayyaawalhormaataaisakamirrattimaatiikeewaliinmarii`atteetta? (Deebiintokkooolnidanda`ama)	1. Jijjiiramaqaamaayeroodar gaggummaa 2. Laguu 3. Of qoqqobuu 4. Walquunnamtiisaalaatursuu 5. Kondomiifayyadamuu 6. Qusannoomaatii 7. Dhukkubootasalqunnamtiindarban-HIV dabalatee 8. Ulfahinbarbaachifne 9. Ulfabaasuu 10. Hariiroowalqunnamttiisaalaaqaamafaallaawajjin 11. Saalqunnamttiimiidhaahinqabne/waliigalteen 12. Qorannoodhiigaafedhiiirrattihundaa`e	
305	Mariinkeessanyoomyoomi?	1. YerooHundaa 2. YerooBaay`ee 3. Darbeedarbee	
306	Waa`eesirnafayyaawalhormaataamatiikeewaliinmarii`atteebeektayoota`eumuriikeewaggaameeqaattijalqabde?	Waggaa _____ tti	

307	Maatiikeealawaa`eesirnawalhormaatafayyaaeenyufa anamarii`atta(marii`atteebeektta)?	1. Ogeessafayyaa 2. Barsiisota 3. Hiriyoota 4. Kanbiraayoojiraateibsi_	
308	Waa`eesirnafayyaawalhormaataairrattimarii`achuufk anatifilattu kami? (Debiintokkooolnidanda`ama)	1. Haadha 2. Abbaa 3. Obboleessa 4. Obboleettii 5. Barsiisota 6. Hiriyoota 7. Ogeessafayyaa 8. Kanbiraayoojiraateibsi_	
309	Matii fi ijoollee isaanii gidduutti mariin waa`ee sirnafayyaa walhormaataa ijoolleen yoo waggaa meeqa ta`an eegaluu qaba jetta?	Waggaa _____ tti	
310	Waa`eesirnafayyaawalhormaataayoomaatiikeewaliin hinmarii`attuta`esababni/sababoonniisaamaali?	1. Aadaatiinfudhatamawaanh inqabneef 2. Qaaniiwaanta`eef 3. Beekumsadhabuumaatii 4. Walittidhufeenyimaatiiifto ominadhabuu 5. Maatiinwaannamahindhag geeffanneef 6. Maatiinhojiinittibay`ata(Y eroohinqabani) 7. Kanbiraayoojiraateibsi_	
311	Hiriyyoonnikeewaa`eesirnafayyaawalhormaataamaa tiiisaaniiwaliinakkamarii`atannijajjabeessitaa?	1. Eeyyee 2. Lakki	

Galatoomaa!!!